Section B

Health Facilities and Services/ Certificate of Need Criteria and Standards

Chapter VIII

Long Term Care

VIII. Long-Term Care

Mississippi's long-term care patients (nursing home and home health) are primarily disabled elderly people, who make up 16.1 percent of the 2005 estimated population above age 65. Projections place the number of people in this age group at approximately 396,745 by 2005, with more than 65,300 disabled in at least one essential activity of daily living.

Providing long-term care for the elderly remains an expensive and complex problem in Mississippi and throughout the United States. In the past decade, Mississippi has experienced increases in both the number and the proportion of elderly people. Nearly 15 percent of the state's elderly people are aged 85 or above. This group of "oldest old" grew by 32.6 percent from 1990 to 2000, whereas the total elderly population grew by only 6.9 percent, and the oldest category is expected to double in size by 2010.

The risk of becoming frail, disabled, and dependent rises dramatically with age. For many years, authorities believed that because people were living longer, the population was healthier. Medical evidence suggests that this assumption is invalid, that in fact, longer life accompanies **increases** in the prevalence of chronic illness and disability. Medicine has been successful in dealing with many acute health conditions, increasing the average length of life. But people are often living longer with, and in spite of, some very disabling chronic conditions, which the health care system can "manage" but not cure. So while the lives of many people have been prolonged through advances in medicine and public health, the quality of an older person's life often suffers. Elders may become dependent on medical technology and on family and professional care providers, and many will need assistance for years — not just weeks or months.

These trends pose tremendous challenges for society. Issues include ensuring an adequate supply of trained caregivers, protecting vulnerable groups, and financing expensive long-term care programs with limited resources. In many cases, the greatest needs of elderly people are not medical, but rather a need for help with the basic activities of daily living, such as bathing and dressing. Many have difficulty with activities that require walking — for example, shopping; yet with proper help many people are still able to remain at home.

The U.S. Census' *Profile of Selected Social Characteristics: 2000* estimates that of the 316,049 Mississippians aged 65 and over, 166,819 (52.78 percent) suffer from some form of disability. Drastic increases occur with advancing age in the number of people reporting difficulties and in the number reporting more than one problem, and the severity of problems is likely to worsen as the years pass. Nursing home use increases significantly as people grow older — only 2.6 percent of the age 65 to 74 population lives in nursing homes, compared to 7.9 percent of the age 75 to 84 population and 23.9 percent of the population over age 85.

Options for Long-Term Care

When people hear the phrase "long-term care," nursing homes generally come to mind. In reality, most people receive long-term care at home or in the homes of family members. Only 9.3 percent of Mississippi's total population over age 65 lived in a nursing home during calendar year 2002. "Long-term care" simply means assistance provided to a person who has chronic conditions that reduce their ability to function independently. Many people with severe limitations in their ability to care for themselves are able to remain at home or in supportive housing because they have sufficient assistance from family, friends, or community services.

The use of services in the community can play a vital role in helping the elderly maintain some degree of independence and postpone or avoid institutionalization for many people. Examples of these community services include adult day care, senior centers, transportation, meals on wheels or meals at community locations, and home health services. The Older Americans Act provides funding for many of these services, along with the federal Social Services Block Grant and state funds. The Mississippi Department of Human Services Division of Aging and Adult Services and the state's ten Area Agencies on Aging coordinate the funds and help people aged 60 and older to obtain services. These agencies work with state and local governments, foundations, and private sector businesses to expand funding at the local level and provide as many services as possible to elderly residents. Tables VIII-1 and VIII-2 show the nature and volume of such services throughout the state.

The Mississippi Division of Medicaid funds and directs a statewide program for home and community-based services under a federally granted Medicaid waiver. Under this program, eligible individuals can choose to receive supportive services in their own homes or in the community rather than enter a nursing home. Services include case management, homemaker assistance, home-delivered meals, adult day care, institutional or in-home respite care, escort transportation, and expanded home health services. Participants in the waiver program must be 21 years of age or older, meet nursing home level of care requirements, and need assistance with at least three activities of daily living. Medicaid eligibility criteria include Supplemental Security Income (SSI) beneficiaries, those covered under Poverty Level Aged or Disabled (PLAD), or those with income under 300 percent of the SSI income level.

While home care costs less per person than institutional care, total state costs can be increased tremendously by the large number of people who would likely sign up for in-home services if Medicaid were to pay for them. National surveys have shown that for every person in a nursing home, there are at least two living in the community who are just as sick. These people either refuse to enter a nursing home or have not been able to find an available nursing home bed in their area. Thus states that expand home and community-based programs through Medicaid waivers may wind up with tremendous increases in the number of people applying for the program and tremendous increases in costs as well. This is a major dilemma that all states must resolve, and its solution may lie in a complete re-formulation of long-term care policies.

Table VIII-1

Division of Aging and Adult Services
In-Home and Community Based Services

FY 2003

Area Agency on Aging	In-Home Services		Community Services		Congregate and Home Delivered Meals	
	Clients Served	Units Served	Clients Served	Units Served	Clients Served	Units Served
Central	2,383	51,552	3,602	113,494	4,927	488,439
East Central	901	36,306	4,918	44,100	1,724	276,027
Golden Triangle	1,249	73,776	2,097	47,984	2,181	298,244
North Central	1,284	14,337	5,553	11,010	3,067	430,940
North Delta	1,372	51,519	412	31,618	1,803	295,373
Northeast	1,785	79,493	1,393	41,665	1,522	205,850
South Delta	1,869	107,045	284	11,763	3,434	314,722
Southern	922	46,108	8,066	155,811	1,960	463,349
Southwest	3,063	45,780	3,031	92,817	2,121	344,629
Three Rivers	1,619	141,884	4,305	43,692	2,017	192,171
Total	**16,447**	**647,800**	**33,661**	**593,954**	**24,756**	**3,309,744**

In-Home Services include: Case Management, Homemaker, Visitation and Telephone Reassurance, Residential Repair, Emergency Response, Respite Care, Special Needs and Medicaid Waiver.

Community Services include: Transportation, Outreach, Adult Day Care, Information and Referral, Ombudsman, Senior Center Activities, Legal, and Senior Discount

Table VIII-2

Community Based Services Client Demographic Mix

FY 2003

Area Agency on Aging	Minority Served	Frail Disabled Served	Rural Served	Below Poverty Served	Below Poverty Minority	Socially Needy Served	Unduplicated Clients Served
Central	4,157	4,420	3,769	4,020	3,094	5,775	6,186
East Central	3,389	753	3,780	6,026	2,711	5,274	7,533
Golden Triangle	1,556	2,287	1,616	1,784	1,178	2,550	2,676
North Central	2,146	2,867	3,507	2,312	1,590	3,141	3,685
North Delta	1,869	2,185	2,125	1,793	1,345	2,389	2,731
Northeast	659	2,573	2,680	1,436	481	2,751	3,029
South Delta	2,864	3,485	2,732	2,875	2,382	3,657	3,718
Southern	2,123	4,955	3,153	4,203	1,621	6,066	6,393
Southwest	3,245	4,342	3,910	3,221	2,351	4,899	5,117
Three Rivers	815	2,510	1,097	1,985	604	2,920	3,230
Total	**22,823**	**30,377**	**28,369**	**29,655**	**17,357**	**39,422**	**44,298**

Source: Mississippi Department of Human Services, Division of Aging and Adult Services

Housing for the Elderly

Policy makers throughout the country are beginning to realize that many elderly people do not need skilled nursing care on a daily basis; they simply need safe, affordable housing and some assistance with the activities of daily living. Several states are exploring ways to expand supportive housing for the elderly. Such housing can take many forms.

"Board and care homes" are residences providing rooms (often semi-private), shared common areas, meals, protective oversight, and help with bathing, dressing, grooming, and other daily needs. Around the country, states license these homes under many different names. The size and type of homes, licensing requirements, staffing, costs, and the type of resident considered appropriate for this type of care vary widely.

In Mississippi these facilities are licensed as personal care homes: Personal Care Home – Residential Living and Personal Care Home – Assisted Living. Both of these facilities provide residents a sheltered environment and assistance with the activities of daily living. Additionally, Personal Care Homes - Assisted Living may provide additional supplemental medical services that include the provision of certain medical services and emergency response services.

The state currently has 194 licensed personal care homes, with a total of 4,783 licensed beds. Mississippi Medicaid operates an Assisted Living Waiver program which is piloted in seven counties: Bolivar, Sunflower, Lee, Hinds, Newton, Forrest, and Harrison. To participate in this waiver, individuals must be 21 years of age or older, meet nursing home level of care, and need assistance with at least three activities of daily living or have a diagnosis of Alzheimer's Disease or other dementia and need assistance with two activities of daily living. Facilities must be licensed by the MSDH as a Personal Care Home - Assisted Living to become a Medicaid provider for participation in the waiver. Individuals will be responsible for the cost of room and board and Medicaid will pay a flat, daily rate for services received within the facility. Services include personal care services, homemaker, chore, attendant care, medication oversight, therapeutic social and recreational programming, medication administration, intermittent skilled nursing services, transportation specified in the plan of care, and attendant call systems. Medicaid eligibility criteria include SSI beneficiaries, those covered under Poverty Level Aged and Disabled (PLAD), or those with income under 300 percent of the SSI income level.

"Retirement communities" or "senior housing facilities" have become common around the state. These communities usually provide apartments for independent living, with services such as transportation, weekly or bi-weekly housekeeping, and one to three meals daily in a common dining room. Many of these facilities include a licensed personal care home where the resident may move when he or she is no longer physically or mentally able to remain in their own apartment. Most facilities do not require an initial fee and do not sign a lifetime contract with their residents. They generally offer only independent living and personal care — most do not include a skilled nursing home as a part of the retirement community.

Another type of retirement center, called a "continuing care retirement community" (CCRC) includes three stages: independent living in a private apartment, a personal care facility, and a skilled nursing home. This type of facility enters into a contract with residents whereby the resident pays a substantial fee upon entering the CCRC and the facility agrees to provide care for the remainder of the resident's life.

Financing for Long-Term Care

Most Americans are astounded to learn of the scarcity of financial help available for long-term care. Many people assume that Medicare pays for these services; in fact, Medicare funds a maximum of 100 days in a Medicare-certified skilled nursing facility only after a hospital stay of at least three days and only if the attending physician certifies the patient as needing skilled nursing or rehabilitative services. Even under these conditions, only the first 20 days are completely covered. For the remaining 80 days, the individual must make a copayment. Furthermore, only 76.6 percent of Mississippi's skilled nursing homes are certified to participate in the Medicare program (141 of 184 nursing homes). The number of nursing homes certified for Medicare has increased substantially in recent years, but many still do not choose to participate in the program.

Swing-beds provide a valuable transition from hospital care for many Medicare-eligible patients who are initially not well enough to go home, but who can return home following an additional period of recuperation. Without the extended care provided in a swing-bed, many of these patients would become nursing home residents. Fifty-two hospitals participated in the swing-bed program during FY 2003 and provided care equivalent to approximately 179 nursing home beds. However, federal law limits the swing bed program to rural hospitals of fewer than 100 beds. Chapter XI offers additional information on swing bed services.

Mississippi also has six Medicare-certified long-term acute care hospitals presently in operation and three additional facilities with CON authority to provide long-term acute care services. These hospitals provide extended care to patients who require no more than three hours of rehabilitation per day but who have an average length of stay greater than 25 days. As with swing beds, these hospitals allow patients a longer period of recuperation to possibly avoid admission to a nursing home.

In addition, licensed acute care hospitals may designate a portion of their beds as a "distinct part skilled nursing facility." These hospitals may then receive Medicare certification as a skilled nursing facility for those apportioned beds if the beds are located in a physically identifiable, distinct part of the hospital and meet all the certification requirements of a skilled nursing facility. A total of 17 hospitals have received approval to participate in this program, with 677 beds approved and 222 in operation.

Medicare also finances home health care when medically necessary and ordered by a physician. This care is more important than ever before as hospital stays become shorter and patients are discharged in a "sicker" condition. However, Medicare regulations require that the patient be housebound, be under the care of a physician, and need either skilled nursing care, physical therapy, or occupational therapy. Chapter XIII provides information on home health services in Mississippi.

Nationally, Medicare has become one of the largest funding sources for home health services, and Medicare funding for short stays in nursing homes is increasing. Nevertheless, Medicare remains a medical model intended to pay for short term acute care, not extended long-term care services.

Medicaid

Medicaid is the primary payor of long term skilled nursing care in the United States. Nearly 18 percent of the Medicaid budget in Mississippi goes to long term care, with approximately 70 percent of the nursing home care funded by Medicaid. However, an individual's assets and income must be very low to qualify for the Medicaid program.

Nursing home care is very expensive, averaging $40,000 a year in Mississippi. Many people enter nursing homes as private pay patients and exhaust their assets after a short time. Then, they must rely on Medicaid to pay for their care. Patients or their families pay for approximately 11 percent of the nursing home care in Mississippi.

Long-Term Care Insurance

Long-term care insurance, a relatively new product in the insurance marketplace, is still evolving to better meet consumers' needs. For some people, a long-term care insurance policy is an affordable and attractive option. For others, the high cost or the benefits they can afford are too small to make a policy worthwhile.

The MSDH recognizes and encourages the efforts of the nursing home industry, working with the insurance industry, the American Association of Retired Persons, and others toward developing a suitable program of long-term care insurance. While not an immediate solution to the problem of funding long-term care, the potential for broader coverage through employer contributions and earlier enrollment at an age where premiums are more affordable does hold promise for improved coverage in the future.

Nursing Facilities

As of May 1, 2004, Mississippi had 18,205 licensed and/or CON approved, but not yet licensed nursing home beds (excluding intermediate care facilities for the mentally retarded). Current formulas indicate a total need of 23,020 skilled nursing home beds, resulting in a projected need for 4,815 additional beds. Map VIII-1 in the criteria and standards section of this chapter presents the state's designated long-term care planning districts, and Table VIII-4 presents the statistical need by county and by district. The inventory of beds does not include 707 (active) beds operated by the Mississippi Department of Mental Health, 600 beds operated by the Mississippi State Veterans Affairs Board, and 120 beds operated by the Mississippi Band of Choctaw Indians. These beds are not subject to Certificate of Need review and are designated to serve specific populations.

To contain escalating costs to the Medicaid program, the Mississippi Legislature placed a permanent moratorium on the construction of new nursing home beds in 1980. However, the Legislature periodically grants exemptions to the moratorium for specific areas of the state. During the 1999 Session, the Legislature authorized the MSDH to issue CONs for 60-bed skilled nursing facilities in 26 counties with the greatest need, for a total expansion of 1,560 beds. The exemption to the moratorium expired in 2003.

MSDH Recommendations

The Mississippi State Department of Health believes that both the state and the nation face an unprecedented challenge as the baby boom generation ages and eventually reaches the ranks of the "oldest old." Throughout the country, planners predict a growing concern with health care needs and cost containment as aging populations challenge the capacity of families, health care institutions, and government to cope.

Mississippi does not have either the number of nursing home beds or the amount of home and community-based services necessary to meet the needs of an increasing chronically impaired population. It is essential that the state evaluate its needs, increase resources wherever possible, and consider policies that will lead to a more efficient approach to long-term care services.

The Department recognizes that long-term care consists of many different services aimed at helping people with chronic conditions compensate for limitations in their ability to function independently. Long-term care frequently does not mean highly technical medical assistance; it more often involves basic assistance with the activities of daily living, such as eating, bathing, dressing, getting to and using the bathroom, and getting in or out of a chair or bed. Sometimes people also need assistance with the instrumental activities of daily living, which include the ability to keep track of money and bills, prepare meals, do light housework, take medicine, use the telephone, and go outside the home.

There are three basic types of services for the elderly: (1) those that enable an individual to remain in his or her own home; (2) those that connect people with the outside world while they are living at home and allow them to interact with others; and, (3) those that provide a back-up system of care for people who can no longer remain at home — an institutional "safe haven" for those who need this level of care. Assessment of an individual's need for assistance with the activities of daily living (ADLs) or instrumental activities of daily living (IADLs) can be used as a measure of which type services the person needs. However, people with cognitive impairments, such as those resulting from Alzheimer's disease, may have no problems with the basic activities of daily living and yet need constant supervision for safety reasons.

The MSDH believes that the following elements can meet the critical needs for nursing home beds: 1) conversion of selected, vacant, acute care hospital beds where such conversion is reasonable and cost-effective; 2) limited construction of additional nursing homes; and 3) expansion of the Division of Medicaid's Home and Community Services Demonstration program.

The MSDH supports the continuing development of alternatives to nursing home care and the funding of a broad spectrum of services for senior citizens. The Department endorses closer coordination of service delivery to elderly persons to prevent the needless duplication of services and to close the gaps in service delivery.

The Department offers the following recommendations:

1. All nursing homes participating in Medicaid should also become certified for Medicare. The state loses substantial Medicare reimbursement each year because only 141 of the 184 licensed nursing homes (76.6 percent) are certified for Medicare participation. Additional revenue is lost because Medicare supplemental insurance policies often will not reimburse for care in a nursing home that is not Medicare-certified. Due to the limited number of certified facilities, Medicare-eligible patients are frequently denied an authorized reimbursement mechanism. In fairness to the nursing homes that are not currently participating in the Medicare program, it is recognized that Medicare has not been and does not intend to be a willing payor for long-term care. Additionally, the Medicare supplemental insurance policies are not intended to be long-term care insurance policies. However, to the extent that short stays in nursing homes are authorized under Medicare coverage and Medicare supplemental insurance, the citizens of the state would be better served if all nursing homes participated in the Medicare program.

2. All agencies and governmental policies should encourage the development of alternatives to nursing home care, such as residential retirement communities, supervised living

apartments, assisted living facilities, personal care homes, adult day care centers, respite care services, and home and community-based services. Programs such as sheltered living and custodial care can adequately meet the needs of many individuals and delay or, in many cases preclude entirely, the necessity for nursing home admission.

3. The Legislature should exempt from the moratorium any freestanding nursing home having fewer than 60 beds to allow expansion up to 60 beds if the other criteria of the current *State Health Plan* are met.

Long-Term Care Beds for Individuals with Mental Retardation and Other Developmental Disabilities

Mississippi had 2,639 licensed beds classified as ICF/MR (intermediate care facility for the mentally retarded) for licensure year 2004. The Department of Mental Health (MDMH) operates five comprehensive regional centers that contain 1,970 active licensed and staffed beds, and five proprietary facilities operate the remaining 669 beds. The residents of the MDMH's regional centers, although they have mental retardation/developmental disabilities, also have severe physical disabilities that result in their requiring care at the nursing home level. Regular nursing facilities are not equipped to serve these individuals.

Map VIII-2 shows the MR/DD Long-Term Care Planning Districts, and Table VIII-5 presents the MR/DD nursing home bed need by Planning District. Both the map and table appear in the criteria and standards section of this chapter. The adopted formula of one bed per 1,000 population less than 65 years of age indicates that the state needs an additional three MR/DD nursing home beds.

The Department of Mental Health has achieved significant progress in developing community living alternatives for persons with mental retardation and developmental disabilities. The prevailing philosophy on the national and state level is to shift emphasis from large institutions to small specialized facilities within the community. Individuals placed in these facilities need long-term treatment programs that may last for several years. In theory, ICF/MR facilities are transitional — individuals should eventually reach a level of functioning that would allow them to move to a less restrictive environment. Rehabilitative and habilitative training programs continue as long as the individual remains in the facility.

Small facilities of ten or fewer beds in size blend better with the community and more closely follow the tenants of the normalization concept than do large institutions. In accordance with this philosophy, the Department of Mental Health continues the development of small ICF/MR community-based group homes and has received or requested funding for 70 such homes.

The Department of Mental Health has also developed small community-based group homes and supervised apartment programs specifically for individuals with mental retardation/ developmental disabilities. Community mental health/mental retardation centers and private, not-for-profit corporations operate additional homes. The homes and apartments must meet MDMH minimum standards for certification. The residents of these programs generally have a higher level of independence than those in the ICF/MR facilities.

Tables VIII-3(A) and (B) show the location and type of both the ICF/MR-licensed community-based homes, the additional community-based group homes, and the supervised apartments for individuals with developmental disabilities.

Alzheimer's Disease and Other Related Dementia

Dementia, a clinical syndrome characterized by the decline of cognitive ability in an otherwise alert individual, by definition involves some memory loss. Other cognitive abilities are frequently diminished or lost, including judgement, learning capacity, reasoning, comprehension, and attention and orientation to time, place, and self. The ability to express oneself meaningfully and to understand what others communicate usually also becomes affected.

The Office of Technology Assessment (OTA), U.S. Department of Health Care Financing, estimates that the prevalence of dementia increases dramatically with age from one percent of those individuals aged 65-74 years old, to seven percent of those 75-84 years, to 25 percent of those aged 85 and over. OTA also estimates that 1.8 million persons in the United States have severe dementia. In addition, one to five million people have mild or moderate dementia. The prevalence could more than triple within the next 50 years if there are no changes in the biomedical knowledge base or clinical management of the disease that causes dementia (OTA, 1992).

In general, health status declines with aging, as individuals become more frail and susceptible to multiple chronic illnesses. Cognitive losses become a leading cause of functional and physical decline. As the disease progresses, the individual begins to experience loss in performing personal care tasks and cognitive-dependent home management tasks. These activities are referred to as activities of daily living (ADL) and instrumental activities of daily living (IADL), respectively. Persons with dementia who need physical and behavioral intervention may include persons ranging from ambulatory individuals who are able to do some ADL tasks to individuals who need total care. Estimates of how many persons need both ADL and IADL services range from nine percent of persons who are 65 to 69 years old to 45 percent or above for those 85 and older. The progression of dementia is not caused by a person's age, but by the loss of functions increasing to total disability. The most acute cases are found among persons who are over the age of 80.

Informal networks of families and other caregivers provide the bulk of the care and services for individuals with dementia. These individuals live in a home-like environment for long periods of time regardless of their severe memory impairment and behavioral dysfunctions. Often the spouses or other caregivers, who endure their loved one’s cognitive loss and assume heavy burdens of care over a prolonged period of time, become the less visible victims of dementia. Individuals with dementia may require constant vigilance by their caregivers because of their unpredictable behavior. As time progresses, the caregivers may begin to experience stress-related illnesses and may become more susceptible to problems of advancing age.

As the individual's illness worsens, the caregiver may require help from formal health services or a facility that offers long term residential services. Alternative services provide a continuum ranging from independent living without outside support to assisted living in the home supported by a community day service. Finally, care-givers may seek help from a residential care facility, a nursing facility, or in rare cases, a psychiatric hospital, if there is a history/evidence of a co-occurring mental illness.

Events which precipitate an individual's move from a home environment to a nursing facility are usually related to circumstances, specific events, or symptoms that cause care-giving in the home setting to be too burdensome, stressful, or unsafe. This decision is usually entailed by sickness and/or death of a spouse or care-giver. The challenge for family and care-givers is to determine when home care becomes inappropriate and institutional care becomes a necessity, not a choice.

The 1999 Legislature temporarily lifted the long-term care moratorium to allow the approval of Certificates of Need for a total of 60 nursing facility beds for individuals with Alzheimer’s Disease (20-bed units in the northern, central, and southern portions of each of the Long-Term Care

Planning Districts), for a total of 240 additional beds. These beds, although far too few, will somewhat alleviate the growing problem of increased numbers of persons with dementia housed in nursing homes.

The MDMH has established the Division of Alzheimer's Disease and Other Dementia, with the responsibility of developing and implementing state plans to assist with the care and treatment of persons with Alzheimer's disease and other dementia, including the development of community-based day programs and training needed by caregivers. Two adult day programs for individuals with Alzheimer's Disease/Other Dementia are currently funded and serving as pilot projects. Central Mississippi Residential Center operates Footprint Adult Day Services in Newton and Region 6 Community Mental Health Center (Life Help) operates Garden Park Adult Day Program in Greenwood. Each program serves 20 persons at a time and presently operates at capacity. The Division of Alzheimer's Disease and Other Dementia, in addition to its main DMH office in Jackson, has satellites in Hattiesburg and Long Beach. A training curriculum for education of caregivers (service providers and family members) has been updated and expanded and was made adaptable to different target audiences. Training has steadily increased since program inception.

Table VIII-3 (A)
Mississippi State Department of Mental Health
Bureau of Mental Retardation
Community Living Arrangements
Group Homes•
FY2003

Provider	Sites
Boswell Regional Center	Brookhaven (3), Hazlehurst (2), Magee (4), Mendenhall (2), Wesson (2)
Ellisville State School	Ellisville (2), Hattiesburg (3), Laurel (3), Prentiss (2) Sumrall (2), Lumberton (2), Columbus, Taylorsville (2), Waynesboro (2), and Richton (2)
Hudspeth Regional Center	Brandon, Meridian (2), Whitfield, Morton (2), Louisville (2), Kilmichael (2), Kosciusko (2)
Mississippi Christian Family Services	Rolling Fork (2)
North Mississippi Regional Center	Bruce (2), Corinth (2), Fulton (2), Hernando (2), Oxford, Tupelo (2), Batesville (2), Senatobia (2), Booneville (2)
Region 1 CMHC	Clarksdale
Region 5 CMHC	Greenville and Cleveland
Region 6 CMHC	Greenwood (2)
Region 7 CMHC	Starkville
Region 14 CMHC	Gautier
South Mississippi Regional Center	Biloxi (2), Gautier (3), Gulfport, Picayune, Poplarville (2), Wiggins (2), Waveland (2)
Willowood	Clinton, Pearl, Jackson

• Ten-bed ICF/MR homes are included in the above chart. The chart does not include 305 individuals served in the HCBs supervised/supported Residential Habilitation programs.

Table VIII-3 (B)
Mississippi State Department of Mental Health
Bureau of Mental Retardation
Community Living Alternatives
Supervised Apartments
FY2003

Provider	Sites
Boswell Regional Center	Magee, Brookhaven
Ellisville State School	Ellisville, Laurel, Columbus
Hudspeth Regional Center	Brandon, Clinton, Pearl
North Mississippi Regional Center	Oxford, Tupelo
Region 14	Lucedale
South Mississippi Regional Center	Gulfport, Biloxi, Picayune
Region 14 Mental Health Center	Lucedale
Region 15, Warren-Yazoo Mental Health Services	Yazoo City
St. Francis Academy	Picayune
Willowood	Jackson

Certificate of Need
Criteria and Standards
for
Nursing Home Beds

Should the Mississippi State Department of Health receive a Certificate of Need application regarding the acquisition and/or otherwise control of major medical equipment or the provision of a service for which specific CON criteria and standards have not been adopted, the application shall be deferred until the Department of Health has developed and adopted CON criteria and standards. If the Department has not developed CON criteria and standards within 180 days of receiving a CON application, the application will be reviewed using the general CON review criteria and standards presented in the *Mississippi Certificate of Need Review Manual* and all adopted rules, procedures, and plans of the Mississippi State Department of Health.

Policy Statement Regarding Certificate of Need Applications for the Offering of Nursing Home Care Services

1. Legislation

   a. The 1990 Mississippi Legislature imposed a permanent moratorium which prohibits the MSDH from granting approval for or issuing a Certificate of Need to any person proposing the new construction of, addition to, expansion of, or conversion of vacant hospital beds to provide skilled or intermediate nursing home care, except as specifically authorized by statute.

   b. Effective July 1, 1990, any health care facility defined as a psychiatric hospital, skilled nursing facility, intermediate care facility, intermediate care facility for the mentally retarded, or psychiatric residential treatment facility that is owned by the State of Mississippi and under the direction and control of the State Department of Mental Health is exempted from the requirement of the issuance of a Certificate of Need under Section 41-7-171 et seq., for projects which involve new construction, renovation, expansion, addition of new beds, or conversion of beds from one category to another in any such defined health care facility.

   c. The 1999 Mississippi Legislature temporarily lifted the 1990 moratorium to allow a 60-bed nursing facility to be added to each of 26 counties with the greatest need between the years 2000 and 2003. The Legislature also permitted CONs for 60 nursing facility beds for individuals with Alzheimer's Disease in the northern, central, and southern parts of each of the Long-Term Care Planning Districts, for a total of 240 additional beds.

   d. Effective April 12, 2002, no health care facility shall be authorized to add any beds or convert any beds to another category of beds without a Certificate of Need.

2. Long-Term Care Planning Districts (LTCPD): The MSDH shall determine the need for additional nursing home care beds based on the LTCPDs as outlined on Map VIII-1. The MSDH shall calculate the statistical need for beds in each LTCPD independently of all other LTCPDs.

3. Bed Need: The need for nursing home care beds is established at:

   .5 beds per 1,000 population aged 64 and under
   14 beds per 1,000 population aged 65-74
   59 beds per 1,000 population aged 75-84
   179 beds per 1,000 population aged 85 and older

4. Population Projections: The MSDH shall use population projections as presented in Table VIII-4 when calculating bed need. These population projections are the most recent projections prepared by the Center for Policy Research and Planning of the Institutions of Higher Learning (March 2002).

5. Bed Inventory: The MSDH shall review the need for additional nursing home beds using the most recent information available regarding the inventory of such beds.

6. Size of Facility: The MSDH shall not approve construction of a new or replacement nursing home care facility for less than 60 beds. However, the number of beds authorized to be licensed in a new or replacement facility may be less than 60 beds.

7. Definition of CCRC: The Glossary of this *Plan* presents the MSDH's definition of a "continuing care retirement community" for the purposes of planning and CON decisions.

8. Medicare Participation: The MSDH strongly encourages all nursing homes participating in the Medicaid program to also become certified for participation in the Medicare program.

9. Alzheimer's/Dementia Care Unit: The MSDH encourages all nursing home owners to consider the establishment of an Alzheimer's/Dementia Care Unit as an integral part of their nursing care program.

Certificate of Need Criteria and Standards for Nursing Home Care Beds

If the legislative moratorium were removed or partially lifted, the MSDH would review applications for the offering of nursing home care under the statutory requirements of Sections 41-7-173 (h) subparagraphs (iv) and (vi), 41-7-191, and 41-7-193, Mississippi Code of 1972, as amended. The MSDH will also review applications for Certificate of Need according to the applicable policy statements contained in this *Plan*; the general criteria listed in the *Mississippi Certificate of Need Review Manual*; all adopted rules, procedures, and plans of the MSDH; and the specific criteria and standards listed below.

Certificate of Need review is required for the offering of nursing home care services, as defined, if the capital expenditure exceeds $2,000,000; if the licensed bed capacity is increased through the conversion or addition of beds; or if nursing home care services have not been provided on a regular basis by the proposed provider of such services within the period of twelve (12) months prior to the time such services would be offered. Certificate of Need review is required for the construction, development, or otherwise establishment of new nursing home care beds regardless of capital expenditure.

1. **Need Criterion: The applicant shall document a need for nursing home care beds using the need methodology as presented herein: The Long-Term Care Planning District wherein the proposed facility will be located must show a need using the following ratio:**

   .5 beds per 1,000 population aged 64 and under
   14 beds per 1,000 population aged 65-74
   59 beds per 1,000 population aged 75-84
   179 beds per 1,000 population aged 85 and older

2. The applicant shall document the number of beds that will be constructed, converted, and/or licensed as offering nursing home care services.

3. The MSDH should consider the area of statistical need as one criterion when awarding Certificates of Need in the case of competing applications.

4. Any applicant applying for nursing home beds who proposes to establish an Alzheimer's/Dementia Care Unit shall affirm that the applicant shall fully comply with all licensure regulations of the MSDH for said Alzheimer's/Dementia Care Unit.

Certificate of Need Criteria and Standards for Nursing Home Beds As Part of a Continuing Care Retirement Community (CCRC)

Entities desiring to establish nursing home beds as part of a CCRC shall meet all applicable requirements, as determined by the MSDH, of the policy statements and general CON criteria and standards in the *Mississippi Certificate of Need Review Manual*, the CON criteria and standards for nursing home beds established in this *State Health Plan*, and the specific CCRC nursing home bed criteria and standards which follow.

Conditions for Exempting Nursing Home Beds In Continuing Care Retirement Communities (CCRC) From the Nursing Home Bed Need Projections in this *Plan*

An existing or planned continuing care or life care facility (CCRC) may develop new or additional nursing home beds or convert domiciliary care (licensed personal care) beds to nursing home beds regardless of the bed need shown in the *State Health Plan*, provided the conditions listed below are met. A planned facility is defined as either a completely new CCRC or additions to an existing component that will result in a facility having the three components described in the aforementioned definition of a CCRC. Beds in an existing or planned CCRC facility may be exempt if development or conversion of these beds conforms to the following, and the applicant agrees to comply with all of the conditions listed on the Certificate of Need and nursing home bed license:

1. For the purposes of CON review, any new nursing home component, which is either a part of a completely new CCRC facility or an addition to existing components, must be developed on-site and simultaneously with, or after the completion of, the residential and domiciliary care components. The independent living accommodations, the domiciliary care beds, and the nursing home components must be operated as one inseparable facility.

2. The usual ratio of nursing home beds to independent living accommodations and domiciliary care units is one nursing home bed to four independent or domiciliary units. Any deviation from this ratio must be documented and justified to the satisfaction of the State Health Officer. For the purposes of CON review, fewer than 60 nursing home beds may be approved as part of a CCRC. However, in no case shall fewer than 30 beds be approved as the initial number of beds authorized for a CCRC.

3. A CCRC desiring to add new beds or convert domiciliary care beds to nursing home beds shall thoroughly document such need. The justification for and the documentation of the need for new or additional beds shall include, but not be limited to, the following:

    a. Evidence that the request for new or additional beds is being made to meet the current needs of residents with whom the facility has an agreement to provide continuing care.

    b. Evidence that the beds to be developed or converted comply or can be brought into compliance with current state licensing standards for such facilities and will comply, without waiver, with any applicable state licensure regulation regarding patient care, construction standards, and/or life safety codes.

c. Evidence that adequate staff and ancillary services will be provided.

d. Evidence that alternatives to institutional nursing care have been utilized to the greatest extent possible.

4. Any nursing home beds developed and those converted from domiciliary care to nursing home beds are limited to exclusive use by persons who have been residents of the facility's independent living units and/or domiciliary living units for at least 30 days, except in cases where one spouse is admitted to a nursing home bed at the time the other spouse takes up independent or domiciliary residence, or when the facility can certify that the disease or injury causing the required nursing home care was not present, known to exist, or was not imminent at the time the person was admitted as a resident.

5. Nursing home beds developed or converted as part of a CCRC shall not be certified for participation in the Medicaid program.

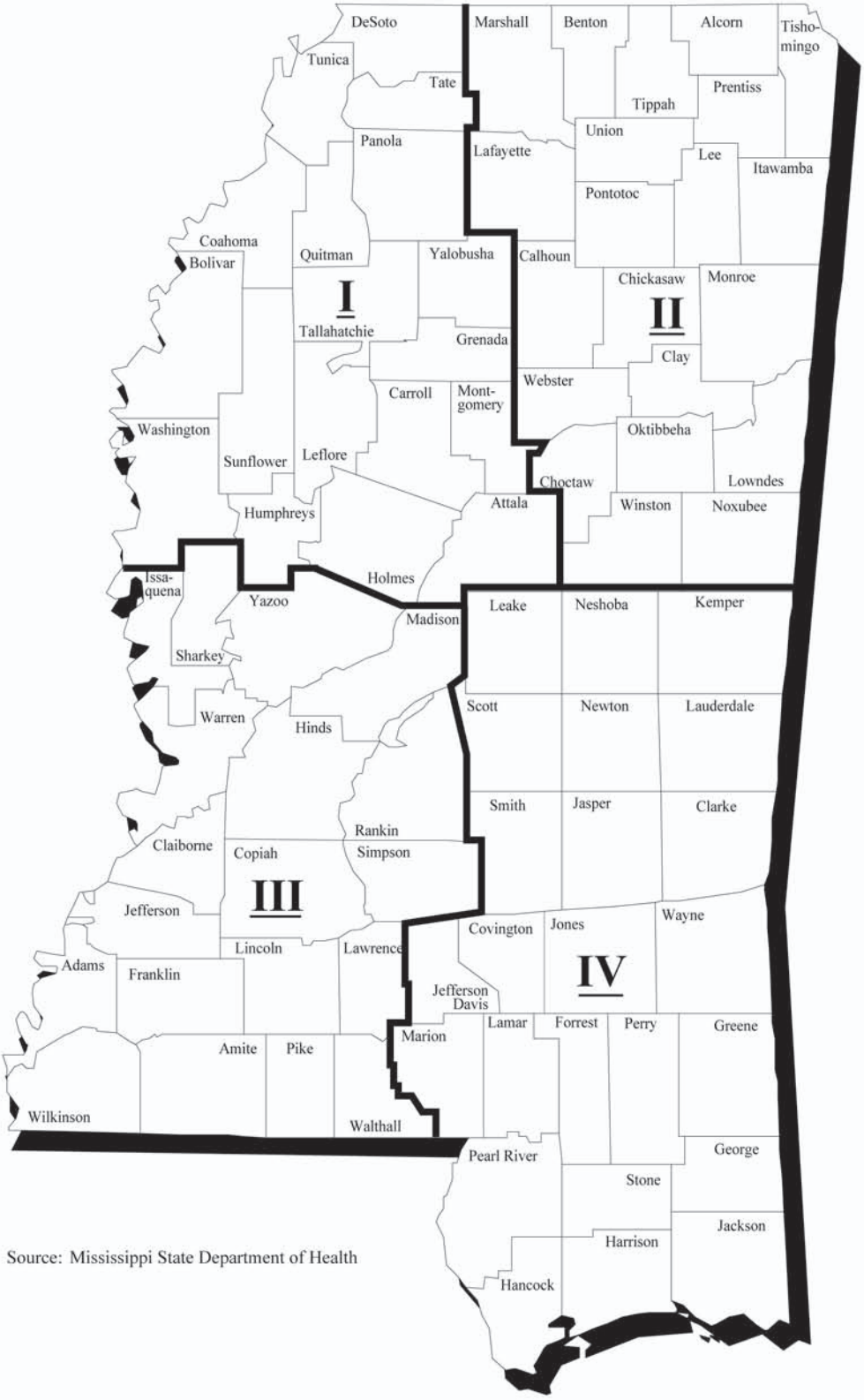
Conditions Under Which Nursing Home Bed Need in this *Plan* is Applicable to the Development of Beds in Continuing Care Retirement Communities (CCRC)

A CON application to develop nursing home beds or to convert domiciliary care beds to nursing home beds shall be subject to the provisions of this *State Health Plan* regarding the identified bed need for nursing home beds and the other applicable CON criteria and standards as shown in this section when:

a. the applicant desires to obtain certification for participation in the Medicaid program, and/or

b. the applicant desires to extend the use of nursing home beds developed or converted to persons who have been residents of the CCRC facility's independent and/or domiciliary units for a period of less than 30 days.

Map VIII-1
Long-Term Care Planning Districts



Source: Mississippi State Department of Health

Table VIII-4
2005 Projected Nursing Home Bed Need

State of Mississippi											
Long-Term Care Planning District	**Population 0 - 64**	**Bed Need (0.5/1,000)**	**Population 65 - 74**	**Bed Need (14/1,000)**	**Population 75 - 84**	**Bed Need (59/1,000)**	**Population 85+**	**Bed Need (179/1,000)**	**Total Bed Need**	**Licensed/ CON-Approved Beds**	**Difference**
District I	473,835	236.92	33,574	470.04	24,938	1,471.34	10,470	1,874.13	4,052	3,533	519
District II	523,270	261.64	41,735	584.29	30,512	1,800.21	13,158	2,355.28	5,001	4,041	960
District III	709,507	354.75	50,050	700.62	36,994	2,182.65	15,635	2,798.68	6,037	4,712	1,325
District IV	888,131	444.07	74,330	1,040.62	49,011	2,891.65	19,853	3,553.69	7,930	5,919	2,011
State Total	**2,594,743**	**1,297.37**	**199,689**	**2,795.65**	**141,455**	**8,345.85**	**59,116**	**10,581.78**	**23,020**	**18,205**	**4,815**

Note: Licensed beds do not include 707 beds operated by the Department of Mental Health, 120 beds operated by the Mississippi Band of Choctaw Indians, or 600 beds operated by the Mississippi Veteran's Affairs Board

Sources: Mississippi State Department of Health, Division of Licensure and Certification; and Division of Health Planning and Resource Development calculations, May 2004
Population Projections: Mississippi Population Projections 2005, 2010, 2015. Center for Policy Research and Planning Mississippi Institutions of Higher Learning, March 2002.

Table VIII-4 (continued)
2005 Projected Nursing Home Bed Need

District I											
County	**Population 0 - 64**	**Bed Need (0.5/1,000)**	**Population 65 - 74**	**Bed Need (14/1,000)**	**Population 75 - 84**	**Bed Need (59/1,000)**	**Population 85+**	**Bed Need (179/1,000)**	**Total Bed Need**	**Licensed/ CON-Approved Beds**	**Difference**
Attala	16,365	8.18	1,625	22.75	1,415	83.48	602	107.76	222	120/60	42
Bolivar	35,136	17.57	2,110	29.54	1,868	110.21	831	148.75	306	410	-104
Carroll	9,645	4.82	898	12.57	595	35.10	247	44.21	97	60	37
Coahoma	26,479	13.24	1,847	25.86	1,510	89.09	655	117.24	245	206	39
DeSoto	114,358	57.18	7,434	104.08	4,132	243.79	1,465	262.24	667	320	347
Grenada	20,477	10.24	1,701	23.81	1,394	82.25	606	108.47	225	257	-32
Holmes	19,039	9.52	1,337	18.72	1,103	65.08	457	81.80	175	148	27
Humphreys	9,409	4.70	654	9.16	505	29.80	230	41.17	85	60	25
LeFlore	33,034	16.52	2,105	29.47	1,895	111.80	850	152.15	310	410	-100
Montgomery	10,203	5.10	989	13.85	828	48.85	361	64.62	132	120	12
Panola	32,187	16.09	2,406	33.68	1,694	99.95	713	127.63	277	190/20	67
Quitman	8,291	4.14	683	9.56	521	30.94	226	40.45	85	60	25
Sunflower	30,298	15.15	1,561	21.85	1,343	79.24	590	105.61	222	236	-14
Tallahatchie	12,501	6.25	1,022	14.31	791	46.67	343	61.40	129	68/60	1
Tate	23,573	11.79	1,799	25.19	1,183	69.80	506	90.57	197	120	77
Tunica	8,645	4.32	508	7.11	385	22.72	157	28.10	62	60	2
Washington	52,906	26.45	3,754	52.56	2,942	173.58	1,263	226.08	479	356/60	63
Yalobusha	11,289	5.64	1,141	15.97	834	49.21	368	65.87	137	72/60	5
District Total	**473,835**	**236.92**	**33,574**	**470.04**	**24,938**	**1,471.34**	**10,470**	**1,874.13**	**4,052**	**3,273/260**	**519**

Table VIII-4 (continued)
2005 Projected Nursing Home Bed Need

District II											
County	**Population 0 - 64**	**Bed Need (0.5/1,000)**	**Population 65 - 74**	**Bed Need (14/1,000)**	**Population 75 - 84**	**Bed Need (59/1,000)**	**Population 85+**	**Bed Need (179/1,000)**	**Total Bed Need**	**Licensed/ CON-Approved Beds**	**Difference**
Alcorn	30,224	15.11	2,903	40.64	2,101	123.96	926	165.75	345	264	81
Benton	6,761	3.38	690	9.66	492	29.03	202	36.16	78	60	18
Calhoun	12,597	6.30	1,208	16.91	1,046	61.71	465	83.24	168	155	13
Chickasaw	16,567	8.28	1,425	19.95	1,038	61.24	470	84.13	174	139	35
Choctaw	8,509	4.25	796	11.14	598	35.28	259	46.36	97	73	24
Clay	19,360	9.68	1,492	20.89	1,167	68.85	519	92.90	192	180	12
Itawamba	19,861	9.93	1,907	26.70	1,349	79.59	573	102.57	219	196	23
Lafayette	36,749	18.37	2,195	30.73	1,513	89.27	688	123.15	262	180	82
Lee	71,347	35.67	5,171	72.39	3,555	209.74	1,550	277.45	595	487	108
Lowndes	54,280	27.14	3,770	52.78	2,729	161.01	1,197	214.26	455	300	155
Marshall	31,358	15.68	2,409	33.73	1,526	90.03	588	105.25	245	120/60	65
Monroe	33,383	16.69	2,926	40.96	2,229	131.51	965	172.74	362	272/60	30
Noxubee	10,848	5.42	817	11.44	635	37.46	267	47.79	102	60	42
Oktibbeha	39,905	19.95	2,124	29.74	1,449	85.49	624	111.70	247	119/60	68
Pontotoc	25,067	12.53	1,934	27.08	1,456	85.90	611	109.37	235	164	71
Prentiss	22,489	11.24	1,996	27.94	1,476	87.08	638	114.20	240	144	96
Tippah	18,737	9.37	1,708	23.91	1,258	74.22	562	100.60	208	240	-32
Tishomingo	16,520	8.26	1,827	25.58	1,370	80.83	559	100.06	215	193	22
Union	22,723	11.36	1,979	27.71	1,520	89.68	641	114.74	243	120/60	63
Webster	8,895	4.45	872	12.21	697	41.12	318	56.92	115	155	-40
Winston	17,090	8.54	1,586	22.20	1,308	77.17	536	95.94	204	180	24
District Total	**523,270**	**261.64**	**41,735**	**584.29**	**30,512**	**1,800.21**	**13,158**	**2,355.28**	**5,001**	**3,801/240**	**960**

Table VIII-4 (continued)
2005 Projected Nursing Home Bed Need

District III											
County	**Population 0 - 64**	**Bed Need (0.5/1,000)**	**Population 65 - 74**	**Bed Need (14/1,000)**	**Population 75 - 84**	**Bed Need (59/1,000)**	**Population 85+**	**Bed Need (179/1,000)**	**Total Bed Need**	**Licensed/ CON-Approved Beds**	**Difference**
Adams	27,898	13.95	2,789	39.05	2,212	130.51	887	158.77	342	274	68
Amite	11,766	5.88	1,186	16.60	848	50.03	348	62.28	135	80	55
Claiborne	10,862	5.43	670	9.38	486	28.67	237	42.42	86	77	9
Copiah	25,494	12.75	1,970	27.58	1,476	87.08	623	111.52	239	180	59
Franklin	7,149	3.57	692	9.69	521	30.74	220	39.38	83	60	23
Hinds	225,123	112.56	14,158	198.21	11,339	669.00	4,862	870.30	1,850	1,417	433
Issaquena	1,870	0.94	173	2.42	82	4.84	38	6.80	15	0	15
Jefferson	8,527	4.26	602	8.43	403	23.78	182	32.58	69	60	9
Lawrence	11,690	5.84	1,100	15.40	709	41.83	287	51.37	114	60	54
Lincoln	29,562	14.78	2,419	33.87	1,949	114.99	795	142.31	306	320	-14
Madison	77,846	38.92	4,241	59.37	3,201	188.86	1,454	260.27	548	395	153
Pike	34,152	17.08	2,847	39.86	2,256	133.10	990	177.21	367	285	82
Rankin	116,763	58.38	7,895	110.53	4,540	267.86	1,691	302.69	740	390	350
Sharkey	5,498	2.75	353	4.94	307	18.11	140	25.06	51	60	-9
Simpson	24,740	12.37	2,089	29.25	1,478	87.20	610	109.19	238	180	58
Walthall	12,873	6.44	1,164	16.30	882	52.04	372	66.59	141	137	4
Warren	44,642	22.32	3,213	44.98	2,323	137.06	1,033	184.91	389	411	-22
Wilkinson	8,674	4.34	699	9.79	563	33.22	253	45.29	93	105	-12
Yazoo	24,378	12.19	1,790	25.06	1,419	83.72	613	109.73	231	221	10
District Total	**709,507**	**354.75**	**50,050**	**700.62**	**36,994**	**2,182.65**	**15,635**	**2,798.68**	**6,037**	**4,712**	**1,325**

Table VIII-4
2005 Projected Nursing Home Bed Need

District IV											
County	Population 0 - 64	Bed Need (0.5/1,000)	Population 65 - 74	Bed Need (14/1,000)	Population 75 - 84	Bed Need (59/1,000)	Population 85+	Bed Need (179/1,000)	Total Bed Need	Licensed/ CON-Approved Beds	Difference
Clarke	15,801	7.90	1,460	20.44	1,155	68.14	473	84.67	181	135	46
Covington	17,450	8.72	1,471	20.59	1,009	59.53	437	78.22	167	60/60	47
Forrest	69,151	34.58	4,200	58.80	3,462	204.26	1,499	268.32	566	656	-90
George	18,402	9.20	1,404	19.66	880	51.92	343	61.40	142	60	82
Greene	13,282	6.64	836	11.70	576	33.98	246	44.03	96	120	-24
Hancock	41,000	20.50	4,247	59.46	2,688	158.59	971	173.81	412	192/50	170
Harrison	172,156	86.08	12,978	181.69	8,429	497.31	3,270	585.33	1,351	856/80	415
Jackson	125,834	62.92	9,402	131.63	5,359	316.18	2,050	366.95	878	528	350
Jasper	16,016	8.01	1,389	19.45	1,021	60.24	453	81.09	169	110	59
Jeff Davis	11,880	5.94	1,014	14.20	789	46.55	341	61.04	128	60	68
Jones	56,181	28.09	5,057	70.80	3,839	226.50	1,526	273.15	598	372/60	166
Kemper	8,836	4.42	806	11.28	637	37.58	295	52.80	106	81	25
Lamar	39,156	19.58	2,560	35.84	1,666	98.29	666	119.21	273	140/40	93
Lauderdale	66,793	33.40	5,387	75.42	4,629	273.11	2,043	365.70	748	592	156
Leake	18,571	9.28	1,589	22.25	1,244	73.40	505	90.40	195	143	52
Marion	22,600	11.30	1,913	26.78	1,487	87.73	635	113.66	239	297	-58
Neshoba	26,165	13.10	2,120	29.68	1,763	104.02	731	130.85	278	178/20	80
Newton	19,371	9.68	1,703	23.84	1,376	81.18	587	105.07	220	120/60	40
Pearl River	46,646	23.32	7,944	111.22	2,562	151.16	951	170.23	456	186/60	210
Perry	11,274	5.64	922	12.91	522	30.80	209	37.41	87	73	14
Scott	24,941	12.47	2,001	28.01	1,430	84.37	593	106.15	231	150	81
Smith	14,199	7.10	1,352	18.93	903	53.28	371	66.41	146	121	25
Stone	13,374	6.69	1,020	14.28	602	35.52	245	43.86	100	149/20	-69
Wayne	19,052	9.53	1,555	21.70	983	58.00	413	73.93	163	90	73
District Total	**888,131**	**444.07**	**74,330**	**1,040.62**	**49,011**	**2,891.65**	**19,853**	**3,553.69**	**7,930**	**5,469/450**	**2,011**

Policy Statement Regarding Certificate of Need Applications for the Offering of Nursing Home Care Services for Mentally Retarded and Other Developmentally Disabled Individuals

1. Legislation

   a. The 1990 Mississippi Legislature imposed a permanent moratorium which prohibits the MSDH from granting approval for or issuing a CON to any person proposing the new construction, addition to, or expansion of an intermediate care facility for the mentally retarded (ICF/MR).

   b. Effective July 1, 1990, any health care facility defined as a psychiatric hospital, skilled nursing facility, intermediate care facility, intermediate care facility for the mentally retarded, or psychiatric residential treatment facility which is owned by the State of Mississippi and under the direction and control of the State Department of Mental Health is exempted from the requirement of the issuance of a Certificate of Need under Section 41-7-171 et seq., for projects which involve new construction, renovation, expansion, addition of new beds, or conversion of beds from one category to another in any such defined health care facility.

   c. Effective April 12, 2001, no health care facility shall be authorized to add any beds or convert any beds to another category of beds without a Certificate of Need.

2. MR/DD Long-Term Care Planning Districts (MR/DD LTCPD): The need for additional MR/DD nursing home care beds shall be based on the MR/DD LTCPDs as outlined in Map VIII-2.

3. Bed Need: The need for MR/DD nursing home care beds is established at one bed per 1,000 population less than 65 years of age.

4. Population Projections: The MSDH shall use population projections as presented in Table VIII-5 when calculating bed need.

5. Bed Limit: No MR/DD LTCPD shall be approved for more than its proportioned share of needed MR/DD nursing home care beds. No application shall be approved which would over-bed the state as a whole.

6. Bed Inventory: The MSDH shall review the need for additional MR/DD nursing home care beds utilizing the most recent information available regarding the inventory of such beds.

Certificate of Need Criteria and Standards for Nursing Home Beds for Mentally Retarded and Other Developmentally Disabled Individuals

If the legislative moratorium were removed or partially lifted, the Mississippi State Department of Health would review applications for MR/DD nursing home care beds under the statutory requirements of Sections 41-7-173 (h) subparagraph (viii), 41-7-191, and 41-7-193, Mississippi Code 1972, as amended. The MSDH will also review applications for Certificate of Need according to the applicable policy statements contained in this *Plan*; the general criteria as listed in the *Mississippi Certificate of Need Review Manual*; all adopted rules, procedures, and plans of the Mississippi State Department of Health; and the specific criteria and standards listed below.

Certificate of Need review is required for the offering of MR/DD nursing home care services, as defined, if the capital expenditure exceeds $2,000,000; if the licensed bed capacity is increased through the conversion or addition of beds; or if MR/DD nursing home care services have not been provided on a regular basis by the proposed provider of such services within the period of twelve (12) months prior to the time such services would be offered. Certificate of Need review is required for the construction, development, or otherwise establishment of new MR/DD nursing home care beds regardless of capital expenditure.

1. **Need Criterion: The applicant shall document a need for MR/DD nursing home care beds using the need methodology as presented below. The applicant shall document in the application the following:**

   a. **using the ratio of one bed per 1,000 population under 65 years of age, the state as a whole must show a need; and**

   b. **the MR/DD Long-Term Care Planning District (LTCPD) where the proposed facility/beds/services are to be located must show a need.**

2. The applicant shall document the number of beds that will be constructed/converted and/or licensed as offering MR/DD nursing home care services.

3. The MSDH shall give priority consideration to those CON applications proposing the offering of MR/DD nursing home care services in facilities which are 15 beds or less in size.

Policy Statement Regarding Certificate of Need Applications for a Pediatric Skilled Nursing Facility

Legislation

a. The 1993 Mississippi Legislature authorized the Department of Health to issue a Certificate of Need for the construction of a pediatric skilled nursing facility not to exceed 60 new beds.

b. A pediatric skilled nursing facility is defined as an institution or a distinct part of an institution that is primarily engaged in providing to inpatients skilled nursing care and related services for persons under 21 years of age who require medical, nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons.

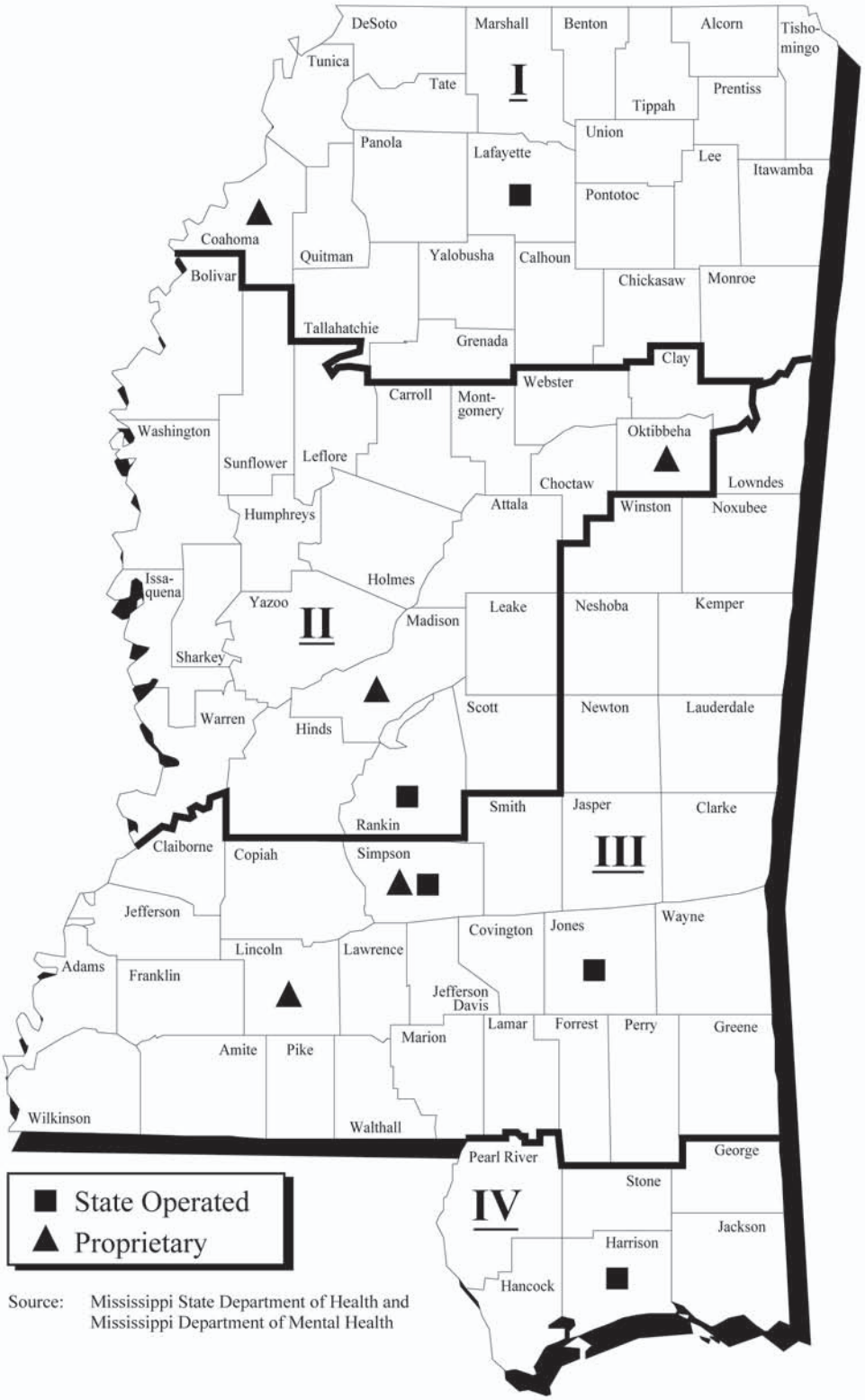
c. The MSDH will review applications for the construction of pediatric skilled nursing facility beds using the general CON review criteria and standards contained in the *Mississippi Certificate of Need Review Manual*, criteria and standards for nursing homes and MR/DD contained in the *State Health Plan*, and all adopted rules, procedures, and plans of the Mississippi State Department of Health.

d. Effective April 12, 2002, no health care facility shall be authorized to add any beds or convert any beds to another category of beds without a Certificate of Need under the authority of Section 41-7-191(1)(c), unless there is a projected need for such beds in the planning district in which the facility is located.

Map VIII-2

Mentally Retarded/Developmentally Disabled Long-Term Care Planning Districts and Location of Existing Facilities

(ICF/MR - Licensed)



Source: Mississippi State Department of Health and Mississippi Department of Mental Health

Table VIII-5
2005 Projected MR/DD Nursing Home Bed Need
(1 Bed per 1,000 Population <65)

	2005 Projected Pop. <65	2003 Licensed Beds	Projected MR/DD Bed Need	Difference
Mississippi	**2,594,743**	**2,639**	**2,592**	**-47**
District I	**622,186**	**562**	**620**	**58**
Alcorn	30,224		30	30
Benton	6,761		7	7
Calhoun	12,597		13	13
Chickasaw	16,567		17	17
Coahoma	26,479	132	26	-106
DeSoto	114,358		114	114
Grenada	20,477		20	20
Itawamba	19,861		20	20
Lafayette	36,749	430	37	-393
Lee	71,387		71	71
Marshall	31,358		31	31
Monroe	33,383		33	33
Panola	32,187		32	32
Pontotoc	25,067		25	25
Prentiss	22,489		22	22
Quitman	8,291		8	8
Tallahatchie	12,501		12	12
Tate	23,573		24	24
Tippah	18,737		19	19
Tishomingo	16,520		16	16
Tunica	8,645		9	9
Union	22,723		23	23
Yalobusha	11,289		11	11

Table VIII-5 (Continued)
2005 Projected MR/DD Nursing Home Bed Need
(1 Bed per 1,000 Population <65)

	2005 Projected Pop. <65	2003 Licensed Beds	Projected MR/DD Bed Need	Difference
District II	**888,616**	**667**	**888**	**221**
Attala	16,365		16	16
Bolivar	35,136		35	35
Carroll	9,645		10	10
Choctaw	8,509		9	9
Clay	19,360		19	19
Hinds	225,123		225	225
Holmes	19,039		19	19
Humphreys	9,409		9	9
Issaquena	1,870		2	2
Leake	18,571		19	19
Leflore	33,034		33	33
Lowndes	54,280		54	54
Madison	77,846	132	78	-54
Montgomery	12,203		12	12
Oktibbeha	39,905	140	40	-100
Rankin	116,763	395	117	-278
Scott	24,941		25	25
Sharkey	5,498		5	5
Sunflower	30,298		30	30
Warren	44,642		45	45
Washington	52,906		53	53
Webster	8,895		9	9
Yazoo	24,378		24	24

Table VIII-5 (Continued)
2005 Projected MR/DD Nursing Home Bed Need
(1 Bed per 1,000 Population <65)

	2005 Projected Pop. <65	2003 Licensed Beds	Projected MR/DD Bed Need	Difference
District III	**668,532**	**1,150**	**669**	**-481**
Adams	27,898		28	28
Amite	11,766		12	12
Claiborne	10,862		11	11
Clarke	15,801		16	16
Copiah	25,494		25	25
Covington	17,450		17	17
Forrest	69,151		69	69
Franklin	7,149		7	7
Green	13,282		13	13
Jasper	16,016		16	16
Jefferson	8,527		9	9
Jefferson Davis	11,880		12	12
Jones	56,181	687	56	-631
Kemper	8,836		9	9
Lamar	39,156		39	39
Lauderdale	66,793		67	67
Lawrence	11,690		12	12
Lincoln	29,562	140	30	-110
Marion	22,600		23	23
Neshoba	26,165		26	26
Newton	19,371		19	19
Noxubee	10,848		11	11
Perry	11,274		11	12
Pike	34,152		34	34
Simpson	24,740	323	25	-298
Smith	14,199		14	14
Walthall	12,873		13	13
Wayne	19,052		19	19
Wilkinson	8,674		9	9
Winston	17,090		17	17

Table VIII-5 (Continued)
2005 Projected MR/DD Nursing Home Bed Need
(1 Bed per 1,000 Population <65)

	2005 Projected Pop. <65	2003 Licensed Beds	Projected MR/DD Bed Need	Difference
District IV	**415,412**	**260**	**415**	**155**
George	18,402		18	18
Hancock	41,000		41	41
Harrison	172,156	260	172	-88
Jackson	125,834		126	126
Pearl River	44,646		45	45
Stone	13,374		13	13

Source: Mississippi State Department of Health, Division of Health Facilities Licensure and Certification; and Division of Health Planning and Resource Development